Webinar Instructions

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- Phone Dial in: 1-866-740-1260
- Access code: 4796665#
- Due to the large number of participants, all lines will be muted during the call.
- If you want to ask a question, please type in your question into the box.
Health Care and Community-Based Organizations: A Win-Win Partnership

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Topics

- CMS Imperative for Health Systems to link to CBOs
- Self Management Supports
- Partnering and Financing
- From The Field: Community Care Linkages in Massachusetts
- Recommendations and Opportunities
- Next Steps
Health Care Delivery System Transformation

1. Acute Health Care System 1.0
   - High quality acute care
   - Accountable care systems
   - Shared financial risk
   - Case management and preventive care systems
   - Population-based quality and cost performance
   ✓ Population-based health outcomes
   ✓ Care system integration with community health resources

2. Coordinated Seamless Health Care System 2.0

3. Community Integrated Health Care System 3.0

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Health Care’s BLIND SIDE

The Overlooked Connection between Social Needs and Good Health

RWJF Physician Survey

• 85% surveyed physicians said that not able to meet patients social needs contributing worsening health
• Top social needs they would write a prescription for include:
  – Fitness program 75%
  – Nutritional food 64%
  – Transportation assistance 47%
• For patients in mostly urban and low-income communities
  – Employment assistance 52%
  – Adult education 49%
  – Housing assistance 43%

http://community.rwjf.org/community/healthcaresblindside
AHRQ Expert Panel Findings:
Barriers to SMS

- Clinicians assume patients know more than they actually do.
- Physicians are used to having control; of being “in charge.”
- Physicians are intervention-driven, action-oriented.
- Providers don’t recognize distress, only behavior.
- Lack of belief that SMS will work.
- Lack of understanding of the whole context for the patient
- A (false) assumption that knowledge leads to action
99% of patient care is done by the patient him/herself.

SMS is not just getting people to do what the clinician wants them to do.

Recognizing the barriers to adopting SMS are similar to those faced by patients.

Providing SMS requires a team effort.

Communication skills are key.
Steps to Build Framework for Sustainability of Self Management Supports

**Step 1: Partnership Models**

- ACL/AoA and NCOA Expert Panel and Interviews
- Vision: Integrated Community Health Care System 3.0
- Framework for Implementation

**Step 2: Financing for Future**

- DHHS, ACL/AoA, NCOA Strategic Session
- Discussion and Findings
Framework to Become Integrated Community Health Care System 3.0

1. Develop Relationships
   • Identify Partners
   • Explore Opportunities to Collaborate

2. Partner
   • Implement Initiatives
   • Identify Value Added

3. Build Capacity
   • Invest in Infrastructure
   • Obtain Funding

Evidenced-Based Self Management Supports
• Entry Point to Partnering
• Gateway to Non Medical Services
• Patient Centered
• Lasting Behavioral Change
• Patient Engagement
Step 1:
Expert Panel on Partnership Models

• Interviews (17 Aging Network, 14 Healthcare Organizations)
  – Perceived value
  – Success factors

• Participants (across 18 states)
  – Federal, state, local health/aging providers, private funders, and potential payers

• Strategies
  – Findings Lead to Step 2
Step 2: Session on Financing for Future

Purpose:

- **Dialogue** to understand how to finance, scale, and sustain self-management programs.
- **Initiate** a private-public sector action agenda to expand self-management programming.
- **Improve** the health and quality of life of individuals with complex and/or multiple chronic conditions.

Meeting Objectives:

- Learn about **successful models**
- Identify the **key requirements and barriers**
- Identify **potential opportunities**
Community Interview Findings: 
*Trends*

- A number of state and regional models offer defined *coordination* with healthcare providers.

- Significant *interest* in the aging network/CBOs in building a new role through health reform to develop new integrated models of EB programs.

- Only a few examples of *integrated* medical/social models where the healthcare and community partners work in a seamless way, and healthcare funding pays for the EB self-management programs were identified.
“Few” Examples from the Field

• The Medicaid Waiver LTSS system pays for CDSMP for enrolled clients under “client training” code (Washington state).

• Medicare reimbursement for Diabetes Self-Management (DSM) exist at a few community-based sites who are partnering with a health provider (Elder Services Merrimack Valley, MA and Age Options, IL).

• Medicare Advantage plans offer CDSMP within health provider wellness centers and limited community contracts (WA, OR, FL).

• United Way grantmaking programs have shown some new interest in SMS initiatives in the community (Seattle-King County, WA; Tarrant County, TX).
Community Interview Findings:

Barriers

• **Infrastructure:** CBO’s face the challenge of how to keep SMS delivery and referral systems viable while the incentive for health funding shifts.

• **Capacity:** Health systems seek to purchase a defined product across a region or state, which may challenge the local structures of CBOs and Area Agencies on Aging.

• **The Case:** the national SMS studies are helpful, but the availability of evidence at a more local level would help in making the case to potential healthcare partners.
Community Interview Findings: Recommendations

- **Share information broadly** on the health, healthcare savings and quality of life benefits of SMS within health reform through new CMS opportunities such as Medicaid waivers, dual-eligible projects, Care Transitions and Patient-Center Medical Home projects
  - For a brochure on the Value of CDSMP: [www.ncoa.org/improve-health/center-for-healthy-aging/content-library/self-management-program.html](http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/self-management-program.html)

- **Seek additional research on outcomes** using Medicare and other healthcare utilization/cost data.

- **Use leadership, policy and regulatory levers** to:
  - Advocate for rate structures that share savings from EB programs with community partners.
  - Recognize lay leaders as qualified members of the health care team.
  - Engage employers to better understand benefits of EB programs for employees and retirees.
Aging Network – An Infrastructure that Supports 11 Million Older Adults and Caregivers

AoA

56 State Units on Aging
629 Area Agencies
246 Tribal organization

20,000 Service Providers & 500,000 Volunteers

Provides Services & Supports to 1 in 5 Seniors

| 242 million meals | 28 million rides | 29 million hours of personal care | 69,000 caregivers trained | 855,000 assisted | 4 million hours of case management | Over 22,000 individuals transitioned | 81,759 individuals completing CDSMP |
Healthcare Organizations Interviews

Focused on the current efforts and future plans to pay for and partner with community based organizations to provide self management supports (SMS).

10 interviews were conducted with:

- Integrated provider and payer health care systems:
- For profit/not-for-profit health insurance plans
- Large not-for-profit physician organization
- State pension fund that provides retirement, disability and survivor benefit programs for public employees
Healthcare Interview Findings: Trends

• Self-insured commercial and employee retiree benefits plans are innovative, flexible, and receptive to self-management supports.

• Health care organizations are searching for opportunities to move from fragmented services & costs to integrated care and community based approach.

• Many are moving from disease management (single disease focus) to integrated model of care driven by care team and care plan.

• All are re-defining systems to deliver cost-effective programs and recognize the need for a progression of strategies to improve quality and reduce costs.

“We have an ethical obligation to provide effective SMS”

Health Plan
Healthcare Interview Findings: Barriers

- **Health Care Culture:** Prefer professional vs. peer led services, measure clinical outcomes vs. quality of life outcomes and tend to own/build vs. buy/partner.

- **Primary Care Physicians:** On-going need for information about SMS available through CBOs, concerns about standard criteria for selection of high quality partners/vendors.

- **Infrastructure:** Inadequate to integrate monitoring and reporting processes, significant technical billing hurdles for CMS and other payers.

- **Priority:** Current focus on high risk/high cost patients whereas lower risk patients may see greatest benefit from self-management
Community Care Linkages is a strategic initiative to effectively integrate services of the Massachusetts Aging Services Access Points (ASAPs) into the evolving healthcare delivery system.

Mass Home Care is a professional association of 27 Not-for-Profit Organizations/ASAPs that manage 70,000 covered lives annually in home care programs (Over $350m of services across MA).

Goals:

- Create new business opportunities for ASAP network
- Form stronger strategic alliances
- Participate in health reform initiatives
- Follow latest developments
CCL: Current Partnering Initiatives

**Payers/Providers**
- SCOs
- ACOs
- ICOs (Dual Eligibles)
- IPAs
- PCMHs
- Hospitals
- SNFs
- HHA

**Services**
- LTSS Coordination: Basic & Complex
- Network Management
- Care Transitions
- Support to Care Managers
- RN Assessments
- Falls Risk Assessment
- Self Management Support (Evidence-based Self Management Support/ Healthy Living Programs)
Atrius Health/ASAPs Practice-Based Pilots

1. Chelmsford & Elder Services of Merrimack Valley
2. Southboro & Baypath
3. West Roxbury & Ethos
4. Concord & Minuteman Senior Services
5. Watertown, Wellesley & Springwell
6. Kenmore & Boston Senior Home Care

Currently expanding to new sites
Population-Based Intervention: Falls Risk Assessment

Atrius Health

- Identify population appropriate for home-based FRA

- Develop standard work for non-medical ASAP intervention (population based, rather than practice or ASAP dependent)

- Develop data capture in Epic to meet Pioneer quality measure
Atrius Health/Southboro Medical Group (SMG) & BayPath

- Social Worker from BayPath to support SMG 24 hours/per wk.
- Access to SMG EpicCare (EHR)
- Provide general community social services
- Participate in case management, quality assurance and quality improvement, utilization review and peer review activities
- Metrics:
  - Number of patients referred
  - Number of ED admissions
  - Number of hospital readmissions
  - Pre- and post-intervention costs
  - Number of cases on-going
  - Number of resistant patients referred – must define non-compliant
Beth Israel Deaconess Physician Organization (BIDPO)/ Springwell

- Springwell-employed **Community Resource Coordinator (CRC)** on site at BIDPO’s office located in Westwood, MA, 3 days per week
- Identify the **most affordable community resource options** available to meet the identified needs of referred Patient regardless of age or ASAP eligibility
- **educate the BIDPO’s CNCMs** and other staff of community resources available, including the abilities of ASAPs
- **identify ASAP clients receiving services** by any of the 27 ASAPs in MA and work with BIDPO staff to identify additional services that may be helpful
- establish a **community resources catalogue** or reference library
- participate with BIDPO staff in **case conferences**
- **Options Counseling visits**
Healthy Living Center of Excellence

- **The Model:** The Healthy Living Center of Excellence will promote the integration of evidence-based self-management programs held in diverse community settings within the health care delivery system through collaboratives which include the community-based organizations, health care providers and plans, government, foundations, and for-profit partners.

- **Founding Partners:** Elder Services of the Merrimack Valley and Hebrew SeniorLife

- **Advisory Team:** Executive Office of Elder Affairs, Department of Public Health, Tufts Health Plan Foundation, Heller School of Brandeis University, Massachusetts Councils on Aging

- **Key Features:**
  * Training Center and Technical Assistance for 14 Evidence Based Programs
  * Diabetes Self-Management Reimbursement under Medicare
  * Integration of CDSMP as a funded intervention under CTTP (3026)
  * CDSMP integration in medical home pilots
  * Diversification of funding for sustainability (HMO, ACO, Foundation, etc)
  * Six (6) regional collaboratives, maintaining local sensitivities
  * Multi-program, multi-venue, across the lifespan approach
  * Focus on workforce development and retention
  * Online self-management programs

[http://www.healthyliving4me.org](http://www.healthyliving4me.org)
Facilitators to Sustain SMS

• **Align payments** with incentives for patients, providers and payers
  — Encourage bundling of services that include SMS

• **Develop an infrastructure** to support data for tracking, evaluating outcomes and billing across health care and community organizations
  — Provide “real time” feedback that programs meet the needs of patients
  — Feedback between community organization, health plan/payer, primary care practice and patient about results of SMS
  — **Communicate results** of engaged and activated patients who achieve “real” behavior/lifestyle change

• **Ability to independently evaluate effectiveness** at the plan/payer level
Next Steps at the National Level

• HHS stakeholder meetings about Multiple Chronic Condition Framework
  – Scaling and Sustaining Self-Management Programs: Sustainable Financing for the Future
  – Identifying and Stratifying Individuals with Multiple Chronic Conditions for Care Management
Bridging medical care and long term services and supports (LTSS) is a critical component to meeting the needs of individuals with chronic conditions and functional limitations, and improving system outcomes. Riskbearing entities present a unique avenue to pursue this integrated vision.
NCOA Focus for the Future

• Self-Management Alliance – MCC Goal 2
  – Public/private collaborative with 7 expert workgroups around scaling self-management

• NCOA National Resource Center
  – Develop quality indicators for an integrated community-based organization/health care model
  – Assist in building the business acumen of the Aging Network
  – Develop a learning collaborative
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